STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445526	A. BUILDING _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An investigation of complaints TN00055442 and TN00055491 was conducted on 10/18/2021-10/20/2021 at Lakeshore Heartland. Health deficiencies were cited in relation to the investigation under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to perform a significant change status assessment when resident enrolled in hospice program for 1 of 5 residents (Resident #5), which had the potential to result in unmet care needs. Review of the Centers for Medicare and Medicaid Services (CMS) guidance on "Resident Assessment Instrument [RAI] and Care Planning," dated 10/2019, revealed "...signifcant change in status assessment [SCSA] is appropriate when...a terminally ill resident enrolls	F 637		

BY: ..... NOV 1 1 2021 RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/4/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

The statements made on this plan of correction are not admission to and do not constitute an agreement with the alleged deficiencies.

F tag 637- Comprehensive Assessment after Significant Change

1. The significant change Minimum Data Set (MDS) for resident #5 was not submitted timely to reflect election of hospice services Resident #5 elected hospice services on 11/05/2019. A quarterly MDS assessment was completed on 1/17/2020 which reflects hospice in section O. A significant change assessment was completed as a late assessment on 4/17/2020 to reflect hospice services elected. All residents who have elected hospice services for this year will be reviewed for significant change assessments and complete any modifications by 11/05/2021.

2. The MDS Coordinator and Interdisciplinary Care Team will be inserviced by the DON on the timeliness of significant change MDS assessments by 10/27/2021. All significant changes will be discussed in the Interdisciplinary Care Team weekly meetings to ensure timeliness of the MDS's.

3. The DON or designee will be responsible for monitoring for compliance. The MDS assessment audit will be completed weekly according to the MDS schedule x 4 weeks.

4. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All Quality Assurance tools, and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.

Completion date will be November 22, 2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 637	Continued From page 1 in a hospice program...the assessment reference date [ARD] must be within 14 days from the effective date of the hospice election...the care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving ...the care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs..." Review of the medical record revealed Resident #5 was admitted on 10/10/2019 with diagnoses which included Cerebral Infarction, Dysarthria, Malignant Neoplasm of bronchus or lung, and Secondary Malignant Neoplasm of brain. Review of the Physician orders revealed an order for Hospice on 11/4/2019. Review of the Quarterly MDS assessment dated 1/17/2020 section O was coded for hospice care while a resident. Further review of MDS assessments revealed on 4/17/2021 a significant change was completed. SCSA revealed section O was coded for hospice care. On 10/19/2021 at 11:30 AM, MDS Coordinator was questioned about SCSA for Resident #5 when she elected hospice care. MDS Coordinator stated, "I was off on maternity leave when she went to hospice, National Healthcare Corporation (NHC) had an RN set up to complete my work but they missed it, so I completed the significant change in April when I got back." Resident #5 went to hospice care on 11/4/2019.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		

Y. [signature] Administrator 11/4/21

The statements made on this plan of correction are not admission to and do not constitute an agreement with the alleged deficiencies.

F tag 641- Accuracy of Assessment

1. The facility Minimum Data Set (MDS) Coordinator failed to accurately complete an assessment on resident #1 with an ARD of 10/08/2021. Resident #8 also found with inaccurate assessment for ARD 10/07/2021. A modification was completed on 10/19/2021 for resident #1 to accurately code section O to reflect hospice services while a resident. Resident #8 had a modification to section M to accurately code pressure ulcer identified upon admission to facility. All admission MDS assessments for this quarter will be reviewed for accuracy and complete any modifications by 11/05/2021.

2. The Interdisciplinary Care Team will be inserviced by the DON or designee on the proper assessment and coding of all sections of the MDS by 10/27/2021. All admission MDS's will now be reviewed each week according to the MDS schedule by the DON or designee to ensure the accuracy and integrity of resident data.

3. The DON or designee will be responsible for monitoring for compliance. The MDS assessment audit will be completed weekly according to the MDS schedule x 4 weeks.

4. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All Quality Assurance tools, and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance. Completion date will be November 22,2021.

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F 641	Continued From page 2 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the facility policy, record review, observation, and interview the facility failed to accurately assess and reflect the resident's status for 2 of 12 sampled residents (Resident #1 and #8), which had the potential to result in unmet care needs. Review of the facility's policy titled, "Patient Care Policies," dated 2/2020, revealed, "...Patients are assessed initially and at regular intervals using a Federal/state specified, standardized, comprehensive resident assessment instrument to identify functional capacity and health status. Care area assessment Triggers [CAA-Care Area Assessment] document the additional assessments performed and serve as the basis for planning individualized patient care. A baseline care plan is developed to address the immediate needs of the patient within 48 hours of the patient's admission...The center will include the attending physician in the development of the patient's plan of care by incorporating the physician's plan of care [order] into the care plan..." Review of the medical record revealed Resident # 1 was admitted to the facility on 10/1/2021 with diagnoses which included Idiopathic Pulmonary Fibrosis (IDF), Atherosclerosis of Coronary Artery, and Essential Hypertension (HTN). Review of the Admission Minimum Data Set (MDS) assessment dated 10/8/2021, revealed section O coded for no special treatments,	F 641		

Y. [illegible] Administrator 11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 3 procedures or programs during the assessment period. Review of the Comprehensive Care Plan dated 10/7/2021, revealed a care plan to address terminal diagnosis/Hospice-Guardian Hospice Services which was not coded on Admission MDS dated 10/8/2021. Review of medical record revealed Resident #8 was admitted on 9/30/2021 with diagnoses which included Alzheimer's Disease, Essential HTN, and Retention of Urine. Review of the Admission MDS assessment dated 10/7/2021 revealed Resident #8 section M coded for no unhealed pressure ulcers. Review of the Physician orders dated 9/30/2021 revealed resident was admitted with orders to cleanse unstageable shearing to sacral area with wound cleanser and pat dry, apply medihoney and cover with foam dressing change twice weekly until healed. During a phone conversation at 10:53 AM on 10/19/2021, MDS Coordinator stated she is aware that Resident #1 was under hospice care. MDS Coordinator was asked about his admission assessment not reflecting hospice care she stated, "No, I didn't catch that I will have to modify it." She confirmed section O of admission assessment is not coded correctly. During an interview with ADON (Assistant Director of Nursing) at 10:00 AM, she was asked to provide a list of pressure ulcers in the building; the list had Resident #8 on current list that confirmed MDS inaccuracy.	F 641		

11/4/21

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

11/4/21

The statements made on this plan of correction are not admission to and do not constitute an agreement with the alleged deficiencies.

F tag 656- Development and implementation of Comprehensive Care Plan

1. Resident #1, #4, #11, #12 did not have interventions to address significant weight loss on their care plans. Resident #1, #4, #11, #12 care plans will be updated to include the interventions for significant weight loss by 10/27/2021. All Residents with significant weight loss will have care plans audited for accuracy and interventions by 11/5/2021

2. The Registered Dietician will be in-serviced by the DON to ensure appropriate interventions are addressed in the care plan for residents with significant weight loss by 10/27/2021. All residents with significant weight loss will be discussed in the Interdisciplinary Care Team weekly meetings to ensure appropriate interventions are care planned.

3. The DON or designee will audit all care plans of residents with significant weight loss for appropriate interventions weekly x 4 weeks then monthly x2 months.

4. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All Quality Assurance tools, and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.

Completion date will be December 4, 2021.

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F 656	Continued From page 5 plan, as appropriate, In accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on facility policy, record review, and interview the facility failed to revise comprehensive care plans for 4 of 12 sampled residents (Resident #1, #4, #11 and #12). Review of the facility's policy titled, "Patient Care Policies," dated 2/2020, revealed, "...Patients are assessed initially and at regular intervals using a Federal/state specified, standardized, comprehensive resident assessment instrument to identify functional capacity and health status. Care area assessment Triggers [CAA-Care Area Assessment] document the additional assessments performed and serve as the basis for planning individualized patient care. A baseline care plan is developed to address the immediate needs of the patient within 48 hours of the patient's admission...The center will include the attending physician in the development of the patient's plan of care by incorporating the physician's plan of care [order] into the care plan..." Review of the Centers for Medicare and Medicaid Services (CMS) guidance on "Resident Assessment Instrument [RAI] and Care Planning," dated 10/2019, revealed "...the care plan is driven not only by identified resident issues and /or conditions but also by a resident's unique characteristics goals, preferences, strengths and needs..." Review of the medical record revealed Resident #1 (resident involved in facility FRI) was admitted	F 656		

Administrator 11/4/21

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F 656	Continued From page 6	F 656		

to the facility on 10/1/2021 with diagnoses which included Idiopathic Pulmonary Fibrosis (IDF), Atherosclerosis of Coronary Artery, and Essential Hypertension (HTN).

Review of the Comprehensive Care Plan dated 10/7/2021, revealed Resident #1 had a potential problem of psychosocial well-being which did not reflect recent involvement in FRI and follow up goal to monitor his well-being post investigation.

Resident #4 was admitted on 2/12/2020 with diagnoses which included Cerebral Infarction, Dysphagia, and Vascular Dementia.

Review of Resident #4 Admission MDS assessment dated 2/2020 revealed MDS section O coded resident to be under hospice care.

Review of the nutritional progress note for 9/6/2021 revealed resident noted to have 9.2 # weight loss x 1 month. Nutritional note continued to state weight loss is anticipated as resident continues on hospice and condition declines.

Review of vitals record report for weights revealed Resident #4's weight on 7/6/2021 was 141.6 pounds (lbs), 8/5/2021 140.8 lbs, 9/1/2021 131.6 lbs, and 9/7/2021 121.6 lbs.

Review of the Care Plan dated 8/23/2021, revealed Resident #4 had a goal: will not exhibit significant weight loss for 120 days. Care plan goal does not reflect present condition of significant weight loss with a goal that is measurable.

Review of the medical record revealed Resident #11 was admitted on 2/2/2021 with diagnoses

11/4/21

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F 656	Continued From page 7 which included HTN, Cerebrovascular Accident (CVA), and Hemiplegia. Review of the Quarterly MDS assessment dated 8/12/2021 section K coded yes to significant weight loss in the last month or last 6 months. Review of the vitals report record for weights revealed Resident #11's weight on 7/6/2021 200.6 lbs, 8/1/2021 191.4 lbs, 8/16/2021 193.4 lbs, 8/27/2021 188.6 lbs, 9/1/2021 188.4 lbs, and 10/4/2021 187.8 lbs. Review of the Care Plan with revision date 9/22/2021 revealed a problem for nutrition/hydration/dental: at risk for complications related to age, CVA, Dysarthria, Facial Weakness, Dysphagia, HTN, Rheumatic Mitral Stenosis, Percutaneous Endoscopic Gastrostomy (PEG) tube in place, past dependence on enteral nutrition, and mechanically altered diet. Nutrition Care Plan does not address current status of significant weight loss post completion of MDS assessment dated 8/12/2021. Review of the medical record revealed Resident #12 was admitted on 7/2/2021 with diagnoses which included HTN, CVA, and Hyperlipidemia. Review of the Quarterly MDS assessment dated 10/8/2021 section K coded for no weight loss. Review of the vitals report record for weight revealed Resident #12 weight on 7/2/2021 128.6 lbs, 8/1/2021 128.6 lbs, 9/21/2021 114 lbs, 10/4/2021 140 lbs, 10/14/2021 109.8 lbs, and 10/19/2021 109.8 lbs. Review of the Care Plan with revision date	F 656		

J. [illegible] Administrator 11/4/21

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F 656	Continued From page 8 10/18/2021 revealed a problem for nutrition/hydration/dental: at risk for complications related to age, CVA, HTN, epilepsy, Hyperlipidemia, Gastroesophageal Reflux disease. Nutrition Care Plan does not address current status of significant weight loss post completion of MDS assessment dated 10/8/2021. Review of the Registered Dietician note for 10/11/2021 stated nutrition: per CNA, 10/4 weight of 140 is inaccurate. Weekly weight of 109.8#, resulting in a -4.2#, -3.68 % weight loss x 3 weeks. CNA states she feeds herself and her appetite is okay. Will add 30 Milliliters (ml) house supplement three times per day to prevent further weight loss. During an interview at 11:00 AM on 10/19/2021, Registered Dietician (RD) was asked about Residents with significant weight loss and addressing this in the MDS assessment. RD stated, "I am not real familiar with the MDS." RD was asked about significant weight loss with Resident #4, #11, and #12 and this change not reflected on the Care Plan. RD stated, "I am not real familiar with the Care Plan process; this is my first position in long term care."	F 656		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy, record review, observation and interview, the facility failed to	F 745		

11/4/21

The statements made on this plan of correction are not admission to and do not constitute an agreement with the alleged deficiencies.

F tag 745- Provision of Medically Related Social Service

1. Documentation of follow up with Resident #1 and POA was not completed following the conclusion of the facility reported incident. Conversation was had with Resident #1's daughter but there was no evidence of documentation of the conversation.

2. The Social Services Director will be inserviced by the DON to ensure appropriate follow up documentation with all facility reported incidents by 10/26/2021.

3. The DON or designee will audit all documentation related to facility reported incidents within 3 days of the conclusion of the investigation to ensure documentation is appropriate.

4. Any concerns identified will be documented on quality assurance tracking log and corrected upon discovery. All Quality Assurance tools, and any findings will be reviewed monthly in the facility Quality Assurance meeting to ensure ongoing compliance.
Completion date: 10/26/2021

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F 745	Continued From page 9 follow up with a resident coping with a stressful event for 1 of 12 sampled residents (Resident #1), which had the potential to result in unmet care needs. Review of the facility's policy titled, "Patient Care Policies," dated 2/2020, revealed, "...Patients are assessed initially and at regular intervals using a Federal/state specified, standardized, comprehensive resident assessment instrument to identify functional capacity and health status. Care area assessment Triggers [CAA-Care Area Assessment] document the additional assessments performed and serve as the basis for planning individualized patient care. A baseline care plan is developed to address the immediate needs of the patient within 48 hours of the patient's admission...The center will include the attending physician in the development of the patient's plan of care by incorporating the physician's plan of care [order] into the care plan..." Review of the facility's policy titled, "Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation," dated 9/14/2017, revealed, "...The patient has the right to be free from abuse, neglect, misappropriation of patient property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the patient's medical symptoms...Abuse also includes the deprivation by an individual, including a caretaker, of goods	F 745		

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F 745	Continued From page 10	F 745		

or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal Abuse: the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability...The center will train all partners, through orientation and ongoing in-services, on the prevention, identification, investigation and reporting of abuse, neglect, misappropriation of patient property and exploitation...The center will provide supervision and support services designed to reduce the likelihood of abuse behaviors...All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors...any partner having either direct or indirect knowledge of any event that might constitute abuse, neglect, misappropriation of patient property or exploitation must report the event immediately, but not later than 2 hours after forming the suspicion...it is the policy of this facility that [abuse]allegation...are reported per Federal and State Law...local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility...the result of all investigation will be competed within five working days of the incident...depending on the result of

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	445526	A. BUILDING _____ B. WING _____	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 11	F 745		

the investigation, all necessary corrective actions will be taken...patients will be protected from harm during an investigation...medical and emotional support will be made immediately available to any individual suffering either alleged abuse, neglect, misappropriation of patient property or exploitation...partners suspected of taking actions that would cause potential harm to a patient or other patients will be immediately placed on administrative leave pending result of investigation..."

Review of the facility's undated policy titled, "Patient Rights," revealed, "...you are entering a health care environment licenses as a [nursing facility]...that means that you will be care for under the rules and regulations that govern [an institution which is primarily engaged in providing skilled nursing care and related services...] this means that you may expect nursing and rehabilitative services in a caring community where all of our efforts are directed toward your comfort and well-being...your plan of care will be developed to address physical and psychosocial area where you and your health care team have concerns. Your plan of care will include an assessment of your strengths and needs. The ultimate goal is to assist you to achieve and /or maintain the highest level of functioning possible within the limits met by your medical condition and your wishes regarding the plan...there are high risks and consequences associated with aging and/or impaired physical condition, including...a high risk of skin breakdown and development of pressure ulcers...the risk of significant weight loss and dehydration if the patients physical condition is currently chronic or

11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445526	A. BUILDING _____ B. WING _____	10/20/2021

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LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

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F 745	Continued From page 12 hereinafter deteriorated...training for professional nurses and nurses' aides, as well as all patient care personnel, is supervised by the DON [Director of Nursing], who is a registered professional nurse licensed in this state..." Review of the medical record revealed Resident #1 (resident involved in facility FRI) was admitted to the facility on 10/1/2021 with diagnoses which included Idiopathic Pulmonary Fibrosis (IDF), Atherosclerosis of Coronary Artery, and Essential Hypertension (HTN). Review of the Admission Minimum Data Set (MDS) assessment dated 10/8/2021, revealed Resident #1 had a BIMS score of 15 indicating intact cognitive abilities. Review of the Comprehensive Care Plan dated 10/7/2021, revealed Resident #1 had a potential problem of psychosocial well-being which did not reflect recent involvement in FRI and follow up goal to monitor his well-being post investigation. Review of the Social Services (SS) progress notes dated 10/7/2021, revealed no progress note related to his involvement in FRI or monitoring of potential psychosocial changes post investigation. During an interview on 10/18/2021 at 10:30 AM with SS related to FRI, she stated, "I didn't think	F 745		

J. [signature] Administrator 11/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 745	Continued From page 13 self reported incidents are placed on the care plan." SS was questioned how was she monitoring his psychosocial well-being, SS stated, "I think it happened on 10/5/2021, he always had family with him, management done immediate staff education." SS further stated, I never called the family just seen them in person, No, I did not address the FRI in my notes or care plan." She further stated the care plan does not go into detail just encourage him to express his feelings. During an observation and interview at 4:10 PM on 10/18/2021, Resident #1 stated its hard for him to breath and I am really weak. Resident #1 stated he wanted to transfer to the Meadows out West where he was previously a maintenance employee. Resident #1 stated but I am to weak right now to transfer. When he was asked about the FRI he stated "yea, he doesn't take care of me anymore it is forbidden." On 10/19/2021 at 3:21 PM Resident #1 was asked if he had spoken with SSD, he stated "yes she has been to my room to check on me". Resident #1 stated, "I don't want them to baby me or nurse me, staff has no personality." He further stated but "overall the nurses treat me well." Resident #1 stated, "With my disease I can't get better only getting worse." Resident #1 is comfortable, glad his family is able to visit, and stated I am ready to go home to be with the Lord."	F 745		

Administrator 11/4/21